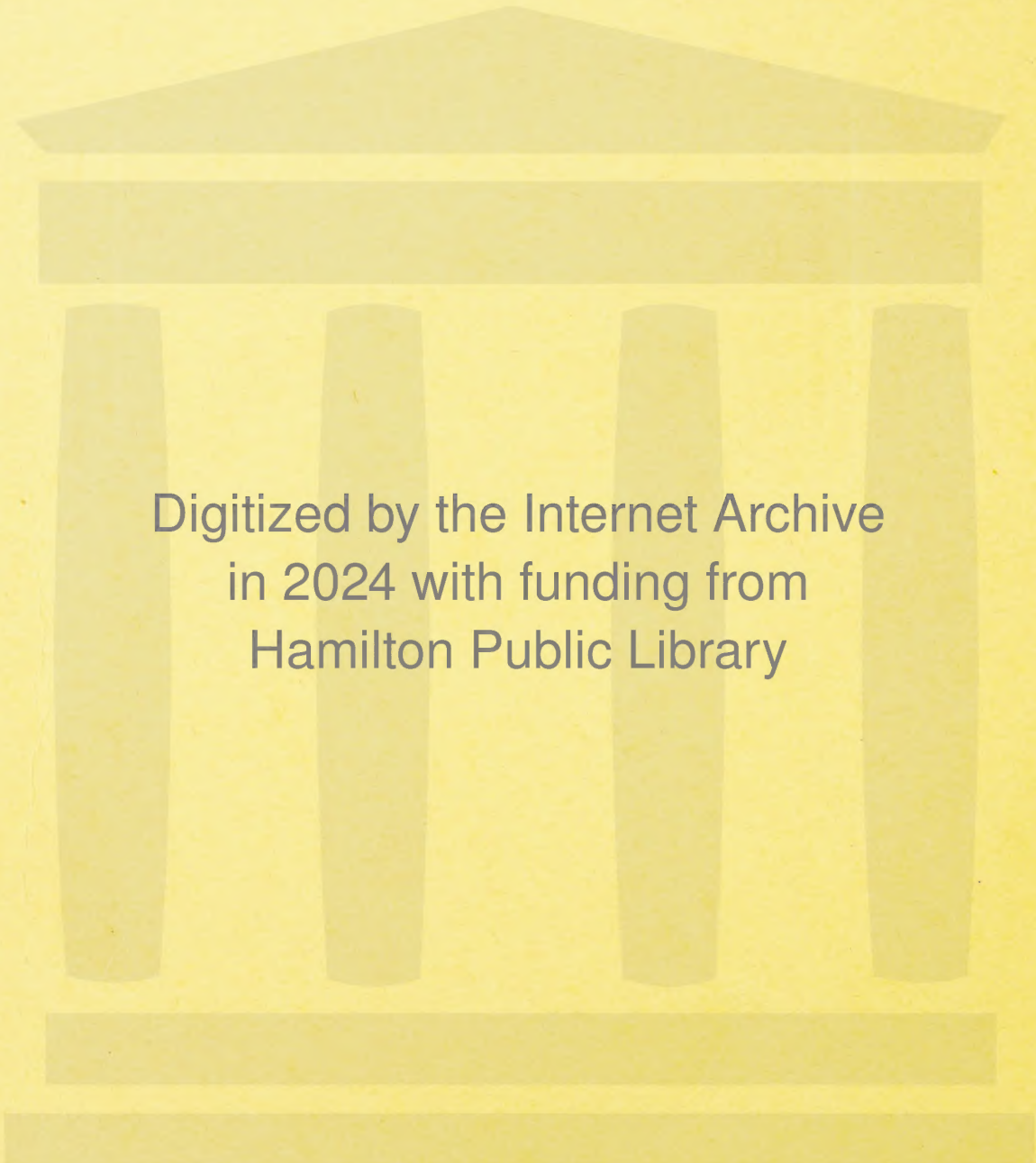
THE REGIONAL MUNICIPALITY OF HAMILTON-WENTWORTH: MEDICAL DIRECTOR'S REPORT



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April 12, 1988

MEDICAL DIRECTOR'S ANNUAL REPORT FOR 1987

1987 was a year of considerable accomplishment, some frustration, and many hopeful signs for future development at Wentworth Lodge. In the spring we had our Accreditation Survey and we are pleased and proud to have been awarded the highest award of the Canadian Council on Hospital Accreditation, a three year accreditation. This achievement will, however, mean at the next survey the Accreditation Team will be looking at us even more closely, so we are not going to be able to rest on our laurels if we hope to maintain the standard.

There was a degree of frustration around the issue of renovations; by the end of 1987 we were still not clear whether the renovations which we hoped for would be carried out in the foreseeable future. Although by the time I am writing this, Stage 1 has been approved and will be starting, there are still many doubts remaining as to the extent and timing of subsequent stages of the renovations. I feel that it is imperative that at least Stage 11 go ahead immediately following completion of Stage 1, both to get improvements in place that I have said for some years were essential to the health and safety of our residents, and to minimize the disruption of their lives.

Finally, we are in the midst of what I regard as exciting discussions with the Education Centre for Aging and Health and McMaster University with a view to having a clinical teaching unit at Wentworth Lodge.

The total number of admissions to Wentworth Lodge remained roughly stable in the past year. Women made up approximately 60% of admissions and men 40%, a proportion similiar to previous years. It is interesting to note (see Table 1) that the proportion of admissions going to Residential Care continues to be roughly stable over the last three years but admissions to Intermediate Care have fallen progressively as admissions to Special Care have risen.

The number of deaths also remains stable; between 35 and 40. (See Table 11)

The average age of people admitted seems to have stabilized finally after years of slowly rising. (see Table 111) Overall we continue to admit patients who are considerably frailer than they were in the earlier years of this institution. This is reflected in the gradual decrease of admissions to Intermediate Care as most of those spaces are taken by people who "graduate" from Residential Care when a bed becomes available. Moreover we are admitting much more cognitively impaired patients to our Special Care Unit. As these people become more impaired they then move to Bed Care. This means that the work load on the nurses in Bed Care has tended to go up as the patients are not only physically but cognitively impaired.

The increase in admissions to Special Care has included a number of patients who have turned out to be physically aggressive and difficult to manage. This has meant problems for the staff and perhaps needs to be dealt with structually as renovations proceed (further comments to follow).

PHYSICAL ENVIRONMENT

In preparing this section of my report, I reviewed my previous reports of 1985 and 1986. It is somewhat frustrating to note that the improvements I felt were urgent in 1985 have not yet been accomplished. I am, however, delighted to note the renovations are beginning in May with the construction of the new wing. Presumably once this is done, we will be able to proceed in stages to necessary improvements to the older wings. In particular I wish to reiterate the urgency with which I think two improvements should be made. In the first place, the call bell system in Residential Care is long overdue. There is no R.N. on duty at night in Residential Care and although hourly rounds are made a patient who becomes ill between rounds is still expected to be able to walk down the hall to the emergency phone. This is a situation which is becoming increasingly unacceptable. Secondly, there is a pressing need for more facilities for hand washing for the staff. We have had two small outbreaks, one of staphlococcal skin infection and the other skin infestation spread from patient to patient by staff. Given the pressures of the work which the staff is required to do and the distance between sinks, it is exceedingly inconvenient for them to wash their hands between each patient. Both of these situations are in need of being corrected before they result in serious problems and potential litigation.

Over the last two years, we have had a marked increase in the number of admissions to Special Care of agitated and aggressive patients. Our staff have learned to cope admirably with this group of patients and, indeed, I think we can say that we are providing exemplary care to a very difficult and taxing patient group. Unfortunately, these patients share a unit with a much milder and (usually) frailer group who are really only in Special Care because of wandering and inability to care for themselves. We have had a number of injuries, some serious, inflicted on this second group by their more aggressive companions. I think serious consideration should be given, in planning Stage 11 renovations, to separating these two subsets of patients requiring Special Care, for the protection of what might be called the 'gentle demented'.

I should note that one improvement that I called for in 1985 has been made; the recreational/physio/occupational therapy staff has been given a specific room and improved equipment. However, further improvements will be needed if and when a Clinical Teaching Unit is established at the Lodge, as the current room would be inadequate for teaching and there is no place to meet.

PATIENT CARE

As Medical Director, I visit Wentworth Lodge three mornings a week. Besides my direct patient care responsibilities, I meet on a regular basis with the Director of Nursing and with the Administrator. I am a member of the Admission and Pharmacy Committees, and am available in a consultative role to several other committees (ie., Infection Control). Moreover, I have educational responsibilities. A number of medical students from every level have chosen electives with me over the last year. There have been one Phase 1 student, two Phase 11 students and two Phase V or final year students. Currently Dr. Bruce McTurk, a third year family medicine fellow, is doing a long term elective at the Lodge. He visits and looks after about a dozen patients weekly under my supervision.

The standards of practice previously adopted are in the process of being reviewed by the medical staff. I anticipate that these will be forwarded in a revised form to the Medical Advisory Committee and to the Social Services Committee by the middle of the year.

The development of a full-scale Quality Assurance Program in the Medical Department remains a major problem for the future. The accreditation survey team accepted our development of Standards of Practice and our regular staff meetings as evidence of the beginnings of a Quality Assurance Program. However, for the next Accreditation Survey, a full program will have to be in effect. St. Joseph's Villa has begun a very elaborate Quality Assurance Program designed by the Percy Group. Unfortunately it is very labour intensive and demanding of physician time, and even if it is successful, it will not be possible to institute an exactly analagous program here at the Lodge. As a first step towards developing a Quality Assurance Program less dependent on physician input, I have asked Mrs. Judith Evans, our Administrator, to get a formal consultation from an expert in Health Records so we can have a realistic and expert opinion on what our needs will be for staffing, space, etc. It seems likely that there will be needs for increased staff and space which will be impossible to escape. It will not be possible to maintain our accreditation, nor to maintain a Clinical Teaching Unit and a link with the university, without an effective and acceptable Quality Assurance Program.

Finally I would be remiss if I did not bring to the Committee's attention the fact that between 1985 and the end of 1987, Wentworth Lodge went from having one of the lowest drug per patient ratios to one of the highest in the Province of Ontario. It is not clear why this should be so. Part of it is an artifact of the recording system; if a drug dosage

changed in the middle of the month, that drug is counted as two drugs for that month. Part of it is undoubtedly a reflection of the increased frailty and the increased number of medical problems of our patients. However, I will be meeting with Dr. Roman Bladek of the Ministry of Community and Social Services, and we will be looking at this problem to make sure it does not reflect bad medical practice.

SUMMARY

1987 has been a year of reward for past endeavours and consolidation of past gains. We face a number of interesting and important challenges in the immediate future as we move ahead with plans to develop a closer relation with the university at the same time as we undertake major and necessary renovations. I look forward to these challenges and sharing them with the staff and administration at the Lodge and at the Division of Services for the Elderly.

Respectfully submitted,

Robert Barkwell, M.D., C.C.F.P.
Medical Director
Wentworth Lodge

RB/ds
attach. Statistical Survey (Table 1, Table 11, Table 111)

cc P. Papp
J. Galloway
J. Evans
M. Jackson

WENTWORTH LODGE

STATISTICAL SURVEY

TABLE I ADMISSIONS AND DISCHARGES

		1985		1986		1987	
Residential Care	- Male	6	20	6	20	9	25
	- Female	14		14		16	
Intermediate Care	- Male	9	16	1	6	2	2
	- Female	7		5		0	
Special Care	- Male	2	8	7	16	8	19
	- Female	6		9		11	
Total	- Male	17	44	14	42	19	46
	- Female	27		28		27	

TABLE II DEATHS

		1985		1986		1987	
Residential Care	- Male	1	1	1	1	2	3
	- Female	0		0		1	
Intermediate Care	- Male	9	16	3	13	3	6
	- Female	7		10		3	
Bed Care	- Male	7	18	7	21	11	26
	- Female	11		14		15	
Special Care	- Male	0	0	2	3	0	4
	- Female	0		1		4	
Total	- Male	17	35	13	38	16	39
	- Female	18		25		23	

TABLE III

	1986	1987
Average age on admission (overall)	80.3	80.1
to Special Care	75.0	78.0
to other areas	84.0	80.8

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February 20, 1990

WENTWORTH LODGE

MEDICAL DIRECTOR'S REPORT FOR 1988 AND 1989

This report is submitted to cover all the activities in Wentworth Lodge over the past two years. This is necessary because 1988's report, submitted along with Dr. Khera's, consisted only of a plea for more staff. Unfortunately, while awaiting a response to that plea, I was caught up in the pressures of other events and no followup was submitted. Equally unfortunately, the response, when it came, was totally unsatisfactory (of which more, below).

Physical Environment

Since my last report, the new wing has been constructed and occupied. The process of construction was, of course, intensely inconvenient for staff, neighbours and residents, especially those residents at the front of the building who had to endure months of noise, dirt and people (visitors, staff and construction personnel) walking through their living quarters.

The end result, however, has proved delightful for residents, who have moved happily to their new quarters. I do not recall hearing one resident complaint about the new wing.

It pains me to have to say that the result has not been so unequivocally positive for staff. To mention only one major problem: the nursing station is in the centre of the wing, the stairwells at the end. As the same staff is now caring for the patients on 2 floors, as previously did on one floor, the extra stress involved can easily be imagined. I can only hope that as the plans for the next phases of renovations are developed, staff will be more involved.

The other issue to be considered with regard to renovations is final bed count. The original proposal for this project envisioned a result in which the bed total would not be significantly different; that is, on the order of 200-210. The most recent proposal which I have heard about foresees a drop of 50-53 beds. This is justified on the basis that these are residential care beds, which we have difficulty filling with properly qualified applicants in any case.

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The flaw in this reasoning is obvious; if we cannot now accommodate all those seeking admission because of their care needs, and if the proportion of elderly in Hamilton-Wentworth is going to continue to grow, then we need those 50 beds in the system and they need to be reclassified. Indeed, as we currently have nineteen patients awaiting a place in our Special Care Unit, I cannot do better than to quote myself: in my 1987 report, I differentiated between the agitated and aggressive and the 'gentle wanderers' and said '...serious consideration should be given, in planning Stage II renovations, to separating these two subsets of patients requiring Special Care, for the protection of what might be called the 'gentle demented'. In my opinion, reducing the bed count would be a terrible error, which, given what we already know about population trends, cannot be justified.

Clinical Teaching Unit

In the past 2 years, enormous steps have been taken in establishing a CTU in cooperation with McMaster University. A memorandum of agreement has been signed, and a formal affiliation agreement is only a few details away from being finalized. However, organization has gone ahead without waiting for this. Maureen Ward, O.T., was hired in conjunction with the University Faculty of Occupational and Physical Therapy. She has proceeded with the development of a student resource centre and a computerized literature reference system. In addition to having students of her own, she has also promoted Wentworth Lodge to the Unit 5 medical students. The result has been encouraging; not only have more students than ever in the past had an experience at Wentworth Lodge, they have, without exception, noted that experience highly in their evaluations. In 1989, 11 Unit 5 medical students, 2 Unit 6 (clinical clerk) students and one BScN student came to Wentworth Lodge under my supervision. In future, I hope to involve others of the medical staff who have university appointments in at least the Unit 5 program.

The next important step will be to hire a clinical nurse specialist with the qualifications for a cross-appointment in the Faculty of Nursing. This is essential, for otherwise we cannot accept BScN students. We believe that our staff has built up considerable expertise in the management of nursing problems in the elderly and that it is critical that these skills be passed on in a formal way to the next generation of professionals. Such a clinical nurse specialist would also have an important role to play in inservice education of existing and newly hired staff.

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Patient Care

"...the level of care required by the residents of Wentworth Lodge is quite heavy, and, in fact, continues to increase. ...we have more than 119 patients who qualify for Extended Care and, if care is to continue at the present high level, more staff, both Health Care Aides and professional, must be found."

- 1985 Medical Director's Report

"...we are admitting much more cognitively impaired patients to our Special Care Unit. As these people become more impaired, they move to Bed Care. This means that the work load on the nurses in Bed Care has tended to go up as the patients are not only physically but cognitively impaired."

- 1987 Medical Director's Report

"The result has been an increasingly onerous work load for the nursing staff. A number of Ministry-sponsored studies have confirmed that, given the functional disabilities of our residents, we are understaffed. ...as of December 1st (1988), we have 125 approved extended care beds and 151 patients with valid extended care certificates."

- 1988 Special Report

I have quoted myself extensively to show that the staffing levels at the Lodge have been a major and growing concern for me for years now. Table 1 demonstrates why: the average age on admission continues to rise inexorably, with a corresponding rise in the level of care required.

TABLE 1 - AGE AT ADMISSION

	1986	1987	1989
To Special Care	75.0	78.0	79.4
To Other Areas	84.0	80.8	83.0
Average	80.3	80.1	81.3

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Patient Care - Continued

TABLE 11 - ADMISSIONS

	1985	1986	1987	1989
Residential Care	20	20	25	12
Intermediate Care	16	6	2	0
Special Care	8	16	19	10
Total	44	42	46	22

There are two things to be gleaned from Table II, one obvious, the other more subtle. The obvious fact is that admissions to Intermediate Care have fallen progressively to nil, evidence that the care needs of residential care residents is such that we always have an internal transfer to fill a bed that comes vacant in Intermediate Care. The more subtle problem is that in 1989, admissions were about half the average for the previous four years. Unfortunately, statistics being what they are, this means an excess of extremely frail patients who are likely to become ill (requiring increased care) and die, thereby triggering, for 1990, an increase in new admissions (requiring increased nursing time).

We have three studies by the Ministry of Community and Social Services for 1984, 1986 and 1988, each of which concludes that we are understaffed. The latest shows that we require 57 staff (RN, RNA, HCA) to cover each 24 hour period. We currently have 49.9; that is, the bare minimum requirements for us to meet our care needs is an additional 7 staff.

TABLE III - STAFFING LEVELS IN HOURS/RESIDENT/DAY

Beacon Hill Lodge	John Noble Home	Wentworth Lodge
2.19	2.29	1.84

Table III is a comparison between Wentworth Lodge and similar local institutions. Beacon Hill Lodge is a large, privately-owned Level II nursing home in Hamilton. The figure of 2.19 staff hours per resident per day is Ministry of Health approved figure for care of a population comparable to that in Intermediate and Special Care and less impaired than our Bed Care residents. The John Noble Home is a municipally-owned Home for the Aged in Brantford and is thus more directly comparable: note that the staffing level is even higher. Indeed, the level at John Noble is almost 25% higher than Wentworth Lodge. This would translate into 12 new direct care staff (RN's, RNA's & HCA's).

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At this point, the problem has become critical. We have been unable to properly implement the Restraint Policy developed in 1987 in both Macassa and Wentworth Lodges because the demands on staff time cannot be accommodated. We have been unable to properly care for a number of patients requiring intermittent catheterization. After virtually eliminating skin breakdown problems by 1987, we are again seeing ulcers. Some of our best nurses have reached the point of burnout. Add to this the load that the CTU will generate (a program already approved by the Committee) and we are coming close to system breakdown.

> "The council of a municipality that establishes and maintains a home...shall, with the approval of the Minister, appoint a legally qualified medical practitioner for the home...WHO IS RESPONSIBLE (my emphasis) for the medical, paramedical and nursing care and services provided to the residents thereof."
>
> - R.S.O. 1980, c. 203, s. 12(4)

I quote the law to show the seriousness with which I take the situation. Indeed, it is almost with desperation that I write this report. I have met to discuss my concerns with the Commissioner of Social Services, Mr. Schuster. He has assured me that he is aware of and shares my concerns and told me that at least 6 new direct care staff positions would be proposed in the budget. I cannot emphasize too strongly that this is a <u>minimal</u> requirement just to meet our present needs. Moreover, I cannot go on writing recommendations that are not acted on and consider myself to have met my legal responsibility. I hope the Committee, and subsequently Regional Council, are able to meet our long-standing and well-documented needs.

It would be unfair of me to point a totally bleak picture of patient care at the Lodge. In general, our staff manages to provide a superior level of nursing care. In addition, Maureen Ward, the CTU cross-appointee, has made good use of the Ontario government's Assistive Devices Program to dramatically improve the seating for many of our residents. Nutrition sevices provide a consistently high standard of food (indeed, many of our residents, when admitted to hospital, complain of the food there) and Sandra Denman, the nutritionist, has provided much help with special diets and other nutrition consultations.

The Activation Program, under Kay Wilkinson, has been very productive. Mrs. Wilkinson has also had a number of students in Recreational Therapy, Physical Education and Gerontology, and not just from Mohawk and McMaster, but from Niagara College and George Brown College as well.

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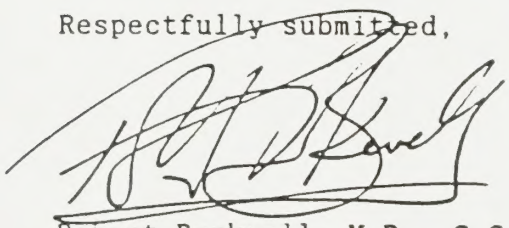
With a proper physio/occupational therapy room, the adjuvant staff have been able to do much more. It is clear, however, that the small amount of physiotherapy input we are able to get from Home Care is inadequate. Consideration will have to be given, within the next 2 or 3 years, to at least a part-time staff physiotherapist.

I trust that this report will be carefully considered by the Committee and by Council. I am, of course, available for clarification or explanation at Committee's convenience.

Respectfully submitted,



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RB/ds

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M. Jackson